National Patient Safety Policy

Suicide Risk Assessment and Prevention Poilcy

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المركز السعودي لسلامة المرضى
SAUDI PATIENT SAFETY CENTER

Introduction

Suicide is a significant healthcare issue. According to The Centers for Disease Control and Prevention (CDC), suicide is the 10th leading cause of death in the United States and the 2nd leading cause of death among 15- to 34-year-olds[1].

In 2 consecutive years, 2020 & 2021, suicide, suicide attempt and self-harm events were among the top five sentinel events categories reported through the SPSC learning and reporting platform.

Saudi Patient Safety Center (SPSC) recognizes the necessity to address the national need to standardize suicide assessment and monitoring across the healthcare system as a significant healthcare issue.

Acknowledgement

The Saudi Patient Safety Center acknowledges and appreciates the input of all healthcare stakeholders and subject matter experts who contributed to the development of this policy.

1. POLICY PURPOSE

The policy intends to recommend a national "Suicide assessment and prevention policy" and highly encourage healthcare institutions to develop internal policies and procedures tailored to their needs and resources to ensure an effective method for suicidal risk assessment and monitoring of patients at risk for suicide.

2. SCOPE

- The policy directive sets out the best practices and minimum requirements to identify and ensure the safe handling of patients with the potential for suicide risk.
- Legal and disciplinary processes are outside the scope of this policy.
- The policy applies to all healthcare settings.

3. DEFINITIONS/ABBREVIATIONS

- **Suicide:** is a death caused by self-directed injurious behavior with any intent to die as a result of the behavior. (CDC definition)
- **Suicide attempt**: is a non-fatal self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury. (CDC definition)

- **Healthcare settings:** In the context of this policy, healthcare settings are referred to outpatient and emergency department (mental health and substance abuse treatment hospitals), emergency department (general hospitals) and mental health inpatient care and/or general hospital level psychiatric or substance abuse treatment.

4. POLICY

As healthcare systems vary greatly across different settings, it is important to recognize the need for tailored tools, inclusion and exclusion criteria to effectively implement policies around readiness, recognition, response, and reporting. While these policies may share common goals, the unique characteristics and capabilities of each healthcare setting must be taken into consideration in order to ensure their successful implementation.

Readiness:

- All healthcare settings need to adopt and use a standardized and validated suicide risk screening and assessment tool.
- *All mental health healthcare institutions and psychiatric units within general healthcare* institutions need to have a standardized and validated environmental risk assessment **(Attachment 2)** that identifies features in the physical environment that could be used to attempt suicide.

- According to the risk assessment, institutions need to consider the necessary actions to minimize this risk (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
- All healthcare institutions need mandatory competency-based education and training for healthcare providers in suicide risk assessment and handling at-risk patients.
- *In emergency department (general hospitals):* The institution needs measures /plans for proper consultation, assessment and referral to mental health/psychiatric services.
- All healthcare institutions need to consider the proper nursing ratio for the patient at risk for suicide.

Recognition:

Patient Screening and assessment:

- The Saudi Patient Safety Center adopted the identified healthcare settings as issued by The Joint Commission and the US national alliance for suicide prevention to screen all the patients using a validated tool starting at age 12 and above.
- There are several screening tools, each with their own limitations, inclusion, and exclusion criteria, select a tool that is suitable for the population being assessed. (e.g., age-appropriate).

- The hospitals may conduct Two types of screenings:
  Initial screening: to identify individuals at risk for suicide who require further assessment and steps to protect them from attempting suicide. Examples of validated screening tools include the *emergency department* Safe Secondary Screener, the PHQ-9, the Patient Safety Screener, the TASR Adolescent Screener, the ASQ Suicide Risk Screening Tool, and The Columbia-Suicide Severity Rating Scale. **(Attachment 3)**

  Second screening (in-depth) for patients screened positive in the initial assessment: Healthcare institutions need to use an evidence-based assessment process or tool in conjunction with clinical evaluation to decide the overall risk for suicide.
  Examples of the Columbia-Suicide Severity Rating Scale **(Attachment 4).** The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

- Healthcare institutions may use screening tools that serve for both Screening and in-depth assessments; Examples include The Safe-T Pocket Card **(Attachment 5)** can be used for both screening and more in-depth assessment of patients who screened positive for suicidal ideation using another too.

Response:

- Based on the setting, healthcare institutions need to have risk minimization measures for patient identified as at risk for suicide. **(Attachment1).**
- In emergency department (general hospitals): a process needs to be in place for referral to Mental health/ Psychiatric consultations/services to maintain patient care.
- Proper counseling, discharge plan and suicide prevention information need be provided to all patients and their families who are found to be at risk for suicide upon discharge.
- Documentation of the plan and required follow-up visits in the patient's medical record.

Reporting:

- All healthcare institutions need to establish a culture of huddles for high-risk patients and post-event debriefs to identify successes and opportunities.
- All healthcare institutions need to report any suicide, attempted suicide, or self-harm that results in severe, temporary harm, permanent harm, or death while being cared for in a healthcare setting or within 72 hours of discharge, including the emergency department as a sentinel event with the detailed root cause and contributing factors.

5. MONITORING PERFORMANCE MEASUREMENT

All health care institutions need to develop an internal performance improvement measure to monitor the implementation of the suicide prevention strategies, which possibly includes a structure, process, and outcome measures.

Example of measures that are being used include:

- Prevalence of suicide behaviors while in care among persons designated as low risk upon initial assessment.
- Rate of suicide attempt or death by suicide within one week of discharge.
- Rate of persons discharged as high-risk for suicide.

6. ATTACHMENTS

1. Attachment 1: **(Table) Classification of Patients needs suicide screening and required interventions for positive risk.**

Setting	Patient type that requires screening	Required intervention for positive risk
Outpatient and Emergency Department *(Mental health and substance abuse treatment hospitals)*	Identify and assess **All Patients**	• Assess for required admission and consider re-assessment upon admission. • Proper patient and family education highlights the risk with decided follow-up appointments.
Emergency Department (General Hospitals)	Identify and assess patients who have harmed themselves, have Mental health or substance abuse conditions (i.e., patients being evaluated or treated for Mental health conditions as their primary reason for care), history or treatment (e.g., Patients on psychiatric medications).	• Consider proper triage category based on patient condition. • Keeping the patient in a risk-free environment, designated room (safe, monitored, and clear of items that the patient could use to harm themselves or others) and safe transfer within or outside the institution. • Close monitoring (one -one observation) • Determine the need for referral to mental health consultation or services, whether they are outside or inside the hospital. • Assess for required admission and consider re-assessment upon admission. • Upon discharge, a proper patient and family education that highlights the risk with a decided follow-up appointment.
Mental health Inpatient Care and/or General Hospital level psychiatric or substance abuse treatment	Identify and assess **All patients** for suicide risk at admission and daily during stay—or more frequently as indicated by level of risk—using a standardized scale.	• Keeping the patient in a risk-free environment (safe, monitored, and clear of items that the patient could use to harm themselves or others) • Close monitoring (one -one observation) • Work with patients and families on a safety plan for their environment immediately post-discharge.

2. Attachment 2: **Environmental Risk Assessment**

EP1 – Environmental Risk Assessment	
Tools	Brief Description
ASHE Patient Safety and Ligature Identification Checklist	The American Society for Health Care Engineering of the American Hospital Association (ASHE) developed multiple tools and resources on ligature risks in the physical environment to help hospitals and other health care facilities understand and implement CMS guidance and Joint Commission recommendations related to establishing a policy to perform an environmental-risk assessment when an at-risk patient is present.
The Mental Health Environment of Care Checklist (MHEOCC) (05/24/2018, XLS	The US Department of Veteran Affairs (VA) developed the Mental Health Environment of Care Checklist (MHEOCC) for VA Hospitals to review inpatient mental health units for environmental hazards. The purpose is to identify and abate environmental hazards that could increase the chance of patient suicide or self-harm.
The Mental Health Guide Settings: Hospitals	The Mental Health Guide was developed by a multidisciplinary team comprising of members from the VA National Center for Patient Safety, Nursing, Safety, Environmental Management, and Interior Design to provide guidance and education to the field in relation to determining products suitable for the locked Inpatient Mental Health Environment. The Guide offers recommended products and solutions, is accessed electronically and was designed to be a "living" document updated as new products are identified and verified. It contains the following resources: • Products and ideas for use in Inpatient Mental Health areas, including both positive and cautionary attributes to consider before purchase. • Products developed by industry with feedback from Integrated Product Team members. • Background to educate staff to evaluate products at the facility level. • Training module and sample checklists for non-clinical staff who may access a locked inpatient mental health unit for routine maintenance and inspection.
Behavioral Health Design Guide Edition 7.3 © 2018 Behavioral Health Facility Consulting, LLC	The Behavioral Health Design Guide is intended to address the built environment of the general adult inpatient behavioral health care unit. The document details practical means of protecting patients and staff. It is intended to represent best current practices, in the opinion of the authors. It is intended to represent best current practices, in the opinion of the authors.
Patient Safety Standards, Materials and Systems Guidelines Recommended by the New York State Office of Mental Health 14th Edition | July 31, 2015 Settings: Inpatient psychiatric units	The purpose of the New York office of mental health environmental guide is to provide a selection of materials, fixtures, and hardware that the NYS-OMH has reviewed and supports for use within inpatient psychiatric units throughout New York State. While installation of these products will not eliminate all risks, the items selected represent styles and properties of products that help lower patient risk while on an inpatient psychiatric unit.

* Adopted from joint commission https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/suicide-prevention/pages-from-suicide_prevention_compendium_5_11_20_updated-july2020_ep1.pdf

3. Attachment 3: **Validated/ Evidence-Based Screening Tools**

Tools	Brief Description
Ask Suicide-Screening Questions (ASQ) Toolkit by National Institute of Mental Health Settings: Emergency Departments, Medical/surgical unit, outpatient primary care, specialty clinics Population: All ages	The ASQ toolkit was developed and validated by a team from the National Institute for Mental Health (NIMH) following a 2008, multisite study. ASQ is a four-item suicide-screening tool designed to be used for people of all ages in emergency departments, inpatient units, and primary care facilities. The toolkit is organized by the medical setting in which it will be used: emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics. The ASQ is free of charge and available in multiple languages. All toolkit materials are available on the NIMH website at www.nimh.nih.gov/asq
Columbia-Suicide Severity Rating Scale (C-SSRS) Triage version Settings: General, Healthcare Population: All ages	The Columbia-Suicide Severity Rating Scale (C-SSRS) evidence-supported screening tool was developed by Columbia University, the University of Pennsylvania, and the University of Pittsburgh supported by the National Institute of Mental Health (NIMH). The C-SSRS Triage version features questions that help determine whether an individual is at risk for suicide. There are brief versions of the C-SSRS often used as a screening tool (first two questions) that, based on patient response, can lead to the administration of the additional questions to triage patients.
Patient Health Questionnaire-9 (PHQ-9) Depression Scale. Settings: Primary Care, BHC Population: adults, age 12+	The Patient Health Questionnaire-9 (PHQ-9) Depression Scale is a validated widely used nine-item tool used to diagnose and monitor the severity of depression. Question 9 screens for the presence and duration of suicide ideation. All screening tools and instruction manuals are available at no cost. https://www.phqscreeners.com/select-screener
Suicide Behavior Questionnaire-Revised (SBQ-R, Osman et al., 2001) Population: ages 13-18	Suicide Behavior Questionnaire-Revised (SBQ-R) The SBQ-R is a 4 item self-report questionnaire that asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones, and includes a question about lifetime suicidal ideation, plans to commit suicide, and actual attempts. Item 1 evaluates lifetime ideation and attempt, Item 2 assesses frequency of ideation in the past 12 months, Item 3 explores suicide threats, and Item 4 evaluates the likelihood of future suicidal behavior.
Suicide risk screening in pediatric hospitals: Clinical pathways to address a global health crisis. Suicide Risk Screening in Pediatric Hospitals: Clinical Pathways to Address a Global Health Crisis - ScienceDirect	This paper details the first interdisciplinary and international effort to generate Clinical Pathways (CPs) for pediatric suicide risk screening in general hospital settings. The Clinical Pathway was created as a guide for hospitals worldwide to improve youth suicide risk screening and implementation of appropriate next steps. The Pathway includes the use of the Ask Suicide-Screening Questions (ASQ) (brief primary screener) and the Columbia Suicide Severity Rating Scale (C-SSRS) or the ASQ Brief Suicide Safety Assessment (secondary screeners) for screening and risk stratification of suicidality in children and adolescents in medical settings.

	The publication includes 4 appendices: • The introductory document (Appendix A) is intended to help orient providers, managers, and administrators in a variety of disciplines and specialties to the pathway. • The flow diagrams (Appendix B: 1-3) visually depict the steps in the clinical pathways for suicide risk screening in the ED (Appendix B.1) and in the pediatric inpatient medical/surgical setting (Appendix B.2). Both pathways describe a similar 3-tiered screening process. Further, a brief suicide risk screening for the C-SSRS was created for hospitals that may already be using this scale (Appendix B.3). • The text document (Appendix C) contains a narrative description of the pathway that is to be used side-by-side with the flow diagrams by individuals or institutions implementing a pediatric suicide risk screening process within their institution.
Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc. Settings: Primary Care, Behavioral Health, Emergency Departments	The Recommended standard care for people with suicide risk: Making health care suicide safe report provides recommendations on suicide-related standard health care for primary care, behavioral health, and emergency department settings. It was produced by health care and suicide prevention experts working with the National Action Alliance for Suicide Prevention (Action Alliance). The information is intended to guide health care organizations that wish to better identify and support people who are at increased risk of suicide and for advocates who will work with hospitals and clinics to make them safer. The report describes why improving suicide care is urgently needed; identifies gaps in health care that contribute to suicide deaths; summarizes the evidence-based solutions that should be adopted; and, provides information on resources that are available to make care safer and better.
ED-SAFE Study Materials The Patient Safety Screener (PSS-3): A Brief Tool to Detect Suicide Risk in Acute Care Settings Settings: Emergency Departments	ED-SAFE is an NIMH-funded, 8-site suicide prevention project. The major goals are to examine: the impact of screening ED patients for suicide risk, the effect of an ED-initiated intervention on suicidal behavior, and the economic impacts of treatment as usual, screening, and the intervention. The ED-SAFE resource collection includes provider guidance and training tools, the Patient Safety Screener to be administered by ED nursing staff and Patient Safety Secondary Screener to assess if referral to mental health treatment is warranted.

*Adopted from joint commission - https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/suicide-prevention/pages-from-suicide_prevention_compendium_5_11_20_updated-july2020_ep2.pdf

4. Attachment 4: **Validated/ Evidence-Based Suicide Risk Assessment Tools**

Tools	Description
Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment version SAFE-T with C-SSRS Settings: All Population: all ages and special populations in different settings	The C-SSRS Risk Assessment version can be used as a suicide assessment tool following the use of one of the screening tools. The risk assessment version provides a checklist of protective and risk factors for suicide, used along with the C-SSRS. The Columbia Protocol questions have also been incorporated into the SAMHSA SAFE-T model with recommended triage categories. See document SAFE-T Protocol with C-SSRS – Recent. Note that the C-SSRS Full version, without the risk assessment, is not sufficient to qualify as an evidence-based suicide risk assessment process. Assessment of the risk and protective factors, in a structured or unstructured way, is required in addition to the suicide inquiry.
Scale for Suicide Ideation – Worst (SSI-W; Beck et al., 1997) settings: In-patient and out-patient settings	The 19-item Scale for Suicide Ideation – Worst (SSI-W; Beck et al., 1997) is an interviewer-administered rating scale that measures the intensity of patients' specific attitudes, behaviors, and plans to commit suicide during the time period that they were the most suicidal. The instrument was developed to obtain a more accurate estimate of suicide risk. As with the SSI, each SSI-W item consists of three options graded according to the suicidal intensity on a 3-point scale ranging from 0 13 to 2. The ratings are then summed to yield a total score, which ranges from 0 to 38. Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The SSI-W takes approximately 10 minutes to administer. (extract from Brown 2003, pg 7).
Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991) Settings: In-patient and out-patient settings	The Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991) is a 21-item self-report instrument for detecting and measuring the current intensity of the patients' specific attitudes, behaviors, and plans to commit suicide during the past week. The BSI was developed as a self-report version of the interviewer-administered Scale for Suicide Ideation. The first 19 items consist of three options graded according to the intensity of the suicidality and rated on a 3-point scale ranging from 0 to 2. These ratings are then summed to yield a total score, which ranges from 0 to 38. Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The last two items assess the number of previous suicide attempts and the seriousness of the intent to die associated with the last attempt. As with the SSI, the BSI consists of five screening items. If the respondent reports any active or passive desire to commit suicide, then an additional 14 items are administered. The BSI takes approximately 10 minutes to administer.

* Adopted from joint commission https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/suicide-prevention/pages-from-suicide_prevention_compendium_5_11_20_updated-july2020_ep3_4.pdf

5. Attachment 5: **The Safe-T Pocket Card**
https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

7. REFERENCES

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